

PLEASE PRINT OR TYPE

## APPLICATION FOR RENTER'S

## REBATE OF ELDERLY RENTERS

RENTER

SEE INSTRUCTIONS AT ASSESSOR'S  
OR LOCAL SOCIAL SERVICES OFFICE

## AND TOTALLY DISABLED PERSONS

FILING PERIOD April 1 - Oct. 1

1. NAME (Last) (First) (Middle Initial)		YOUR BIRTH DATE (Mo. Day, Yr.) / /		YOUR SOCIAL SECURITY NO. - -	
2. SPOUSE'S NAME (Last) (First) (Middle Initial)		SPOUSE'S BIRTH DATE (Mo. Day, Yr.) / /		SPOUSE'S SOCIAL SECURITY NO. - -	
3. PRESENT MAILING ADDRESS (No. and Street)			CITY OR TOWN (Don't Abbreviate)		STATE ZIP CODE
4. RENTAL ADDRESS IN CT IF DIFFERENT THAN ABOVE			CITY OR TOWN		STATE ZIP CODE
5. FILING STATUS: CHECK ONLY ONE: <input type="checkbox"/> MARRIED <input type="checkbox"/> UNMARRIED SURVIVING SPOUSE (AGE 50 TO 65) PROOF REQUIRED IF SPOUSE IS A RESIDENT OF A HEALTH CARE OR A NURSING HOME FACILITY IN CT AND ON TITLE XIX PROOF REQUIRED CHECK HERE: <input type="checkbox"/> IF APPLICANT IS TOTALLY DISABLED CURRENT PROOF REQUIRED: CHECK HERE: <input type="checkbox"/>					
6. WHAT % OF RENT AND UTILITIES DO YOU PAY? (Husband and Wife are considered to be one (1) renter) %					
7. TOTAL RENT AND UTILITIES YOU ACTUALLY PAID. \$					
8. DID OR WILL YOU FILE A FEDERAL TAX RETURN FOR LAST YEAR? <input type="checkbox"/> - YES (Attach Copy) <input type="checkbox"/> - NO					
9. PUBLIC ASSISTANCE RECIPIENTS PLEASE NOTE: You may receive LESS than the TENTATIVE GRANT on Line 20 below.					
10. DID YOU RENT IN CONNECTICUT FOR THE ENTIRE CALENDAR YEAR? YES NO			11. IF THE ANSWER TO (10) IS "NO", ENTER DATES YOU RENTED:		Starting Mo. Yr. Ending Mo. Yr.
12. INCOME RECEIVED DURING LAST CALENDAR YEAR: A. GROSS INCOME - Includes: Federal Adjusted Gross income or its equivalent. Also includes, but is not limited to, wages, lottery winnings, taxable pensions, IRA's, interest, dividends and net rental income. A. \$ B. NON-TAXABLE INTEREST - Example: Interest from Tax Exempt Government Bonds B. \$ C. SOCIAL SECURITY OR RAILROAD RETIREMENT INCOME - Add Medicare premiums (Attach SSA 1099) C. \$ D. ANY INCOME NOT REFLECTED IN THE ABOVE - Examples: Federal Supplemental Security Income, Veteran's Pensions, Veteran's Disability Payments, and any other income not listed above. D. \$ SPECIFY SOURCE OF INCOME: E. TOTAL Add lines 12A through 12D E. \$					
APPLICANT'S/ AUTHORIZED AGENT'S AFFIDAVIT		The applicant or authorized agent deposes that the above statements are true and complete and claims tax relief under provisions of the Connecticut General Statutes. The property for which tax relief is claimed, is the permanent residence/domicile of the applicant. He/she is not receiving State Elderly tax benefits under section 12-129b, section 12-170aa, in any town. I grant permission to the Department of Social Services to release to the Office of Policy and Management information necessary to help determine my eligibility. The penalty for making a false affidavit is the refund of all grants improperly taken and a fine of \$500.00 or imprisonment for one year, or both. Your signature signifies that this affidavit has been read and understood.			
SIGNATURE OF APPLICANT OR AUTHORIZED AGENT X		Date signed (Mo. Day, Yr.) / /		APPLICANT'S OR AGENT'S PHONE NO. (INCL. AREA CODE) ( )	
STOP! DO NOT WRITE BELOW THIS LINE - FOR ASSESSOR'S USE ONLY					
13. Amount of rent and utilities paid from Line 7 \$ X.35 \$					
14. CREDIT COMPUTATION: QUALIFYING INCOME <input type="checkbox"/> FULL YEAR-\$ x.05 OR <input type="checkbox"/> PART YEAR - \$ X (No. of Months / 12) x.05 = \$					
15. Subtract Line 14 from Line 13. If zero or negative amount, there is no benefit. Enter -0- on Line \$					
16. Indicate table used: <input type="checkbox"/> Unmarried <input type="checkbox"/> Married					
17. MAXIMUM CREDIT ALLOWED A. FULL YEAR: amount per table OR B. PART YEAR: amount per table X (No. of Months/12) = \$					
18. Enter amount from Line 15 or Line 17, whichever is LESS \$					
19. Minimum per table \$					
20. Enter GREATER of Line 18 or 19 TENTATIVE GRANT (Subject to review by Off. of Policy and Management)					
ASSESSOR'S AFFIDAVIT		- I am satisfied that the above named applicant meets all the necessary statutory requirements - This claim is disallowed for the following reason: _____			
SIGNATURE OF ASSESSOR OR MEMBER OF ASSESSOR'S STAFF					Date signed (Mo. Day, Yr.) / /